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	155756	A. BUILDING 00 B. WING	10/19/2012

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COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN 46804

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: October 15, 16, 17, 18, and 19 , 2012 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 Survey team: Julie Wagoner, RN, TC Tim Long, RN Christine Fodrea, RN Census bed type: SNF: 27 SNF/NF: 107 Total: 134 Census payor type: Medicare: 24 Medicaid: 66 Other: 44 Total: 134 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/29/12 Cathy Emswiller RN	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after November 18, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interviews, the facility failed to ensure care plans related to behaviors were initiated timely and/or were individualized for 6 of 10 residents reviewed for unnecessary medications. (Resident #18, 41, 80, 151, 175, and 247) Findings include: 1. The clinical record for Resident #41 was reviewed on 10/18/12 at 9:30 A.M. Resident #41 was admitted to the facility on 07/27/12	F0279	**F 279 Develop Comprehensive Care Plans** It is the practice of this facility to develop, review and revise each resident's comprehensive plan of care using the results of the assessments completed on each resident. The care plan will include measurable objectives and timetables to meet each resident's needs in the following areas; mental, psychosocial, and medical. **What corrective action(s) will be accomplished for those residents found to have been**	11/18/2012

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	from an acute care hospital. The resident's diagnoses included but were not limited to: Acute T2 T3 compound fracture, falls, dementia, osteoporosis, glaucoma, venous-statis, carpal tunnel syndrome, and compression fracture. Nursing progress notes, dated 07/30/12 at 8:46 P.M. indicated the resident was upset about being at the facility and wanted to go home. She moved her wheelchair backwards into the wall in frustration and the handle of the wheelchair put a hole in the wall. On 08/04/12 at 10:06 P.M., the resident became upset because her closet did not contain all of her clothes. In addition the resident continued to want to go home. On 08/05/12 at 6:37 P.M., the resident was agitated again and wanted to go home. She kept asking people to give her a ride. An order for Ativan was obtained. On 08/06/12 at 10:00 P.M., the resident again expressed the desire to "go home." Staff explained why she was at the facility and gave her a pain pill and she was calmer.		**affected by the deficient practice**: · Interdisciplinary Team (IDT) will review residents #18, #41, #80, #151, #175, #247 affected by the alleged deficient practice and update the care plans to the individual needs of those residents in accordance with the specific behaviors that are listed for that resident. Social Services will discuss with the psychiatric clinician on or before 11/18/12 regarding psychotropic medication management for those residents that were affected and make necessary changes as recommended by the psychiatric clinician or neurologist. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · Residents having psychotropic medications have the potential to be affected by the alleged practice. · Licensed staff and members of the interdisciplinary team including social services will be in-serviced on the behavior management program including development of the comprehensive care plan.	

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	On 08/07/12 at 1:09 P.M. the resident was again upset about the "missing clothes" in her closet and wanted to go home. An order for a urinalysis was obtained. On 08/08/12 at 12:22 A.M., Resident #41 was agitated again about her missing clothes. The resident thought she was "at home" and her clothes had been taken from her closet. The nursing staff explained she only brought 5 shirts and two were in the closet, two were in the hamper, and one was in the laundry. The resident insisted she had a "whole closet full of clothes." Staff then "quizzed" her about the name of her home (assisted living facility resident had been residing in prior to fall). On 08/09/12 at 9:22 A.M., the resident again began repeatedly asking for her "things." She indicated she had clothes, her purse, and her other "stuff." Staff attempted to reorient the resident but she became very distraught, did not believe the staff, thought her items had been stolen. The resident was given Ativan to help her "rest." On 08/12/12 at 11:16 A.M., the resident started asking to go home. The resident asked staff and visitors		Education will be provided by Social Services Consultant/Designee and completed by November 18 th , 2012. · A house audit will be implemented by Social Services and will begin using a tool for tracking of psychotropic medications for all residents who are on psychotropic medications to ensure that all behavior management and comprehensive care plans are in place in a timely fashion and individualized for each resident. All new admissions and readmissions are reviewed in a.m. meeting with IDT to ensure the care plan, diagnosis, behavior tracking flow sheets are individualized and in place. **See Exhibit A.** **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** · Licensed staff and members of the interdisciplinary team including social services will be in-serviced on the behavior management program including development of the comprehensive care plan. Education will be provided by Social Services Consultant/Designee and completed by November 18 th , 2012.	

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	for a ride home, asked to call her family. She then became agitated because she was not in her "home." She was redirected and informed social services and therapy would discuss the issue with her tomorrow and talk about her discharge plans. At 5:00 P.M., the resident became agitated and loud, tried to exit the facility repeatedly. The resident was medicated with Ativan for anxiety and given 1:1 attention which was effective. On 08/13/12 the resident's attending physician order Haloperidol, an antipsychotic medication and Trazadone, an antidepressant medication with sedating side effects. A physician's note, dated 09/07/12, indicated the Haloperidol was ordered due to "delusional disorder." On 8/31/12, a note to physician, indicated the resident continued to have problem behaviors through past week - screaming and hitting staff when they don't open the door for her or ask her to sit down in her wheelchair - asked to change Haldol and Trazadone to Risperidone. The request was not responded to by the physician.		· IDT to review all medication orders using the tool for tracking of psychotropic medications to ensure behavior management tracking and comprehensive care plans are individualized and initiated timely including by not limited to diagnosis, behavior flow sheet listing the specific behaviors to support the diagnosis and indication for psychotropic medication. **See Exhibit A** ·DNS is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ·A CQI monitoring tool called Psychoactive Medication/Behavior Management will be utilized every week x 4, monthly x 3 and every other month x 3 for at least 6 months. **See Exhibit B** ·Data will be collected by DNS/Designee and submitted to the CQI Committee. If threshold of 95% is not met, an action plan will be developed. ·Non-compliance with facility procedure may result in disciplinary action up to and including termination. Completion Date 11/18/12	

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	On 08/24/12 another note to physician indicated the resident has had many problem behaviors in the past week. She was "exit seeking, ramming w/c into staff, scratching, screaming at staff...her moods worsen at 6 PM...Ativan seems to help her to calm but takes awhile." Review of the behavior tracking for Resident #41 for August 15 - 31, 2012 indicated it tracked the following behaviors: #1 - anxiety aeb [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] fidgeting and worrisome thoughts such as people stealing her things and #2 - Insomnia aeb [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] not sleeping 6 - 8 hours daily. There were no behaviors noted on the tracking form for August 2012. An October 2012 behavior tracking form indicated the following behaviors were being tracked: #1 - anxiety aeb [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] fidgeting and worrisome thoughts such as people stealing her things			

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	#2 - Insomnia #3 - Verbal and physical agitation/aggression. There was no behavioral tracking or care plan to address the delusional behavior for which the resident was being administered, Haldol. In addition, prior to the order for the Haldol, there was no documentation of delusional disorder.. Review of the current heath care plans for Resident #41 indicated they included a plan, initiated on 08/20/12 for aggressive behaviors, a plan, initiated on 08/15/12 for insomnia, and a plan, initiated on 08/15/12 for anxiety. There were no care plan initiated prior to the obtaining and administration of both antianxiety, antipsychotic, and/or antidepressant medication. Interview with Nursing Consultant , employee #9 and Social Services Consultant, employee #10, on 10/19/12 at 11:00 A.M.., indicated the physician who had taken care of resident while she was in an assisted living facility had ordered the Haldol and indicated the reason was delusions. The Nurse Consultant indicated she was checking with the physician to see if there was anymore			

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	in site as to the reason Haldol was ordered. There was no further information obtained from the physician at the time of the survey exit for the facility. 2. The clinical record for Resident #18 was reviewed on 10/18/12 at 10:00 A.M. Resident #18 was admitted to the facility on 05/22/2008, with diagnoses including but not limited to, depression with withdrawal and decreased motivation, dylipidemia, reflux, personality disorder with borderline features, hx of hysterectomy, ddd, htn, moderate obesity, increased cholesterol, djd, dementia, bipolar disorder, delusions, gerd, seasonal allergies, dry eye, oad, hyperlipidemia, and diabetes mellitus. Review of the physician orders for Resident #18 indicated she was receiving, Lamictal, a mood altering medication, Fazaclo, an antipsychotic medication, Namenda, a medication to treat dementia, and Exelon patch, an antidepressant medication. Review of the current behavior tracking and health care plans for Resident #18, current for October 2012, indicated the following behaviors were being tracked: #1 - Hx of alteration in mental process			

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	with potential for injury to self, family members and/or staff and #2 - Manipulative behavior. Interview with Social service designee, employee #5, on 10/19/12 at 11:00 A.M. indicated she had not been working in the facility very long and was not able to discuss behavior tracking and antipsychotic medication use for Resident #18. Interview with the Social services consultant, employee #10, on 10/19/12 at 11:10 A.M., indicated the care plan regarding behavior tracking for Resident #18 was not clear as to what to what the actual behavior being tracked. 3. The clinical record for Resident #175 was reviewed on 10/18/12 at 2:30 P.M. The resident was admitted to the facility on 10/19/11 and readmitted to the facility on 07/02/12 with diagnosis, including but not limited to falls with fracture and scalp lacerations, senile dementia, insomnia, anemia, anxiety, and hx of urinary tract infection. Physician's orders, dated 04/20/12 indicated an order for Ativan .5 mg every 8 hours as needed for anxiety. On 05/03/12 an order was received			

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	for Ativan .5 mg every 8 hours routinely for anxiety. On 05/10/12 an order to utilize the as needed Ativan could be used for anxiety induced by insomnia, along with the routinely ordered Ativan as long as the resident did not receive more than 2 mg of Ativan in a 24 hour period. A care plan regarding anxiety was not initiated until 06/29/12. The resident was readmitted for an acute care facility on 07/04/12. Physician orders on 07/04/12 indicated the resident was receiving Ativan, an antianxiety medication, twice a day and as needed for anxiety and/or agitation, and Exelon patch for depression, and an antidepressant, Remeron at bedtime. On 07/09/12 an order for Ambien, a hypnotic was ordered at bedtime per a family request due to insomnia. On 07/11/12, the Ambien was discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia. On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat restless leg syndrome, Lyrica was			

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	also added. Review of the care plans for Resident #175 indicated plan, current through 12/11/12 for Behavioral symptoms - signs and symptoms of anxiety, insomnia, and depression. The only plan to address restless leg syndrome indicated a plan to administer the medication. No non-pharmaceutical interventions were documented. Review of the nursing progress notes from 07/04/12 - 07/09/12 indicated there was no documentation of any insomnia behavior. Nursing notes, from 07/10/12 - 07/11/12 indicated there was no documentation again of any increased insomnia issues. Nursing notes, from 07/12/12 - 07/27/12 indicated on 07/18/12 the resident had some insomnia around 4:00 A.M., however the resident was being tested for a possible urinary tract infection. On 07/23/12 the resident's husband informed staff the resident was anxious and not sleeping well. The urinalysis test was still pending with the laboratory at the time. There were no interventions besides family at bedside and medications documented as having been attempted regarding the insomnia.			

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	Interview on 10/19/12 at 8:45 A.M., with the Director of Nursing Consultant, employee #10, indicated in June 2012 the Corporate Social Service staff did a "webinar" inservice with facility social service staff regarding antipsychotic reduction action plans in regards to CMS initiatives. Then the Corporate Social Services staff conducted "conference calls" with facility Social Services staff throughout the summer. Interview with Social Services Consultant, on 10/19/12 at 10:00 A.M., indicated the facility is working towards an individual tracking plan to make sure the behavior and care plans were in place for residents receiving antipsychotic medications. 4. The clinical record for Resident #80 was reviewed on 10/17/12 at 1:30 P.M. Resident #80 was admitted to the facility on 08/04/2007 with **d**iagnoses including but not limited to: CVA (cerebral vascular accident), Alzheimer's, Osteoporosis, htn (hypertension), allergic rhinitis, dementia with behavior disturbance, delusions, depression, hyperlipidemia, hypothyroidism, osteoarthritis, left hemiplegia, dementia, Brady cardiac, and pvd (peripheral vascular disease).			

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Review of the physician's orders indicated an order, dated 07/31/12 for the antipsychotic medication, Zyprexia.

Review of a "Behavior Events" note, dated 05/10/12 at 4:23 P.M. indicated the resident was exit seeking, yelling out "help" loudly, scratching, pulling hair, and attempting to bite staff when redirected. The resident was moved to a quiet area and given space. An order for the antianxiety medication, Ativan was obtained. In addition, a urinalysis test was obtained. The resident had currently been receiving antibiotic medication for an eye infection.

Review of nursing progress notes and behavior tracking forms for May 2012 indicated there were no other behaviors documented to support the use of the Zyprexa for Resident #80.

Behavior tracking records for June 2012 indicated on 06/11/12 on the evening shift the resident exhibited three episodes of either exit seeking or wandering in her wheelchair into other resident's rooms. The non-pharmaceutical interventions attempted were documented as effective. However, on 06/12/12, the

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	physician increased the resident's Zyprexa to 5 mg at bedtime due to dementia with behavioral disturbances. The care plan, current through 11/2012, indicated a plan to address the resident's resistiveness to care. The plan indicated the resident would yell, hit, kick, bite, scratch, pinch to indicate that she does not want to get up or receive care. There was also a plan regarding the resident's delusional behavior however, delusions and resistive behaviors were not being tracked on the behavior tracking records.. Interview, on 10/19/12 at 11:00 A.M., with both Social Service Directors, employees #4 and 5 indicated they had only been at the facility for a short time and did not feel they could discuss Resident #80's psychotropic medications and/or behaviors. 5. Resident #247's record was reviewed 10-17-2012 at 10:37 AM. Resident #247's diagnoses included but were not limited to dementia, high blood pressure and an enlarged heart. A review of a current physician's			

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	order summary dated 10-2012 indicated Xanax (an antianxiety medication) 0.5 milligrams (mg) had been ordered every 6 hours as necessary for anxiety. A review of the Medication Administration Record (MAR) indicated resident #247 had received Xanax 0.5 mg 10-13, 10-15, and 10-16 for anxiety. A note on the back of the October MAR indicated all doses were effective. There was no indication non-pharmacological interventions had been attempted. In an interview on 1-17-2012 at 11:08 AM LPN #1 indicated interventions attempted prior to as necessary dosing were on the back of the MAR or in nurse's notes. A care plan titled depression as evidenced by tearfulness, sad expression, and verbalization dated 10-12-2012 included interventions of encourage to voice emotions, refer to psychiatrist as needed, talk to resident about favorite things, and redirect to an activity. There was no care plan that included anxiety, or anxiety medication use. In an interview on 10-17-2012 at 1:12			

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	155756	A. BUILDING 00 B. WING	10/19/2012

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	PM SSD #4 indicated behavior tracking was on the MAR. In an interview on 10-17-2012 at 1:13 PM LPN #1 indicated behavior tracking was in the MAR. She further indicated Resident #247 had not been tracked as far as she knew for behaviors. LPN #1 further indicated non pharmacological intervention should have been attempted before as necessary Xanax was used. In an interview on 10-17-2012 at 1:15 PM SSD #4 indicated no behavior had been tracked because the physician had just changed the medications and there was no tracking necessary. SSD #4 further indicated there should have been a care plan addressing use of Xanax and anxiety. 6. Resident # 151's clinical record was reviewed on 10/17/12. The record indicated the resident was admitted to the facility on 9/12/12 and had diagnoses including, but not limited to, dementia with delusions and depression. Review of resident # 151's physician's orders indicated the resident has been receiving Risperdal (an			

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	antipsychotic medication) 0.25 milligrams (mg) by mouth at bedtime for dementia with delusions since admission. Review of the resident's health care plans, current through 12/11/12, indicated there was no health care plan for dementia with delusions. No health care plans were located for the use of Risperdal. An interview with LPN #5 on 10/17/12 at 1:15 p.m. indicated the resident had no health care plan related to Risperdal use for dementia with delusions. An interview with the assistant director of nursing (ADN) on 10/17/12 at 1:20 p.m. indicated behavior tracking for residents was kept in the medication administration records (MAR). The ADN indicated review of resident #151's MAR did not contain any behavior tracking. An interview with resident #151's Social Service coordinator, employee #15, on 10/17/12, indicated the resident had no health care plan for dementia with delusions and no behavior tracking. 3.1-35(a)			

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	3.1-35(b)(1) 3.1-35(b)(2)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interviews, and record review the facility failed to ensure a care plan regarding releasing a waist restraint as a reduction plan was followed consistently for 1 of 1 residents reviewed for restraints. (Resident #198) Finding includes: On 10/15/12 at 12:25 P.M., Resident #198 was observed seated at a dining room table on the secured dementia unit. The resident was seated in her wheelchair with a seatbelt type restraint in place. The resident was served her noon meal and was noted to be able to feed herself. On 10/17/12 at 1:47 P.M., Resident #198 observed propelling self in wheelchair around secured unit. The resident had a seat belt type waist restraint on. The resident was asked if she could remove the seatbelt and the resident was cued to the seat belt clasp. Resident stated "Probably so" but did not follow through and try to	F0282	**F 282 Services by qualified persons/per care plan** It is the practice of this facility to ensure that care plans are carried out by qualified persons. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident #198 restraint will be released during meals, personal care, and while under direct supervision of staff to be in compliance with restraint reduction per plan of care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other Residents were affected by this alleged deficient practice. · No other residents have restraints in the building. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:**	11/18/2012

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	remove seat belt clasp. Observation 10/18/12 11:15 A.M., Resident #198 was seated in her wheelchair in the day lounge area of the secured unit. The seatbelt type waist restraint was in place. The resident was awake and participated in finish the phrase activity. At 11:58 A.M., the unit manager propelled resident in her wheelchair from the lounge to the dining room table. The resident's waist restraint was not released. The resident was observed to remained seated in her wheelchair with a waist restraint in place through 12:21 P.M.. The resident had received her meal, had her food set up for her to eat, but the waist restraint remained in place and was not released. The clinical record for Resident #198 was reviewed on 10/18/12 at 8:49 AM. The resident had been admitted to the facility on 07/03/12. Nursing notes and physician orders indicated a waist restraint was initiated on 07/03/12. Review of the care plan regarding restraint use for Resident #198, initiated on 07/16/12 and current through 12/10/12, indicated the following reduction plan: may be		· A restraint flow sheet will be placed in resident #198 MAR to ensure restraint is being released per plan of care. The licensed nurse will conduct rounds to ensure compliance on all three shifts. **See Exhibit C** · The Staff Development Coordinator/Designee will in-service all licensed staff on or before November 18, 2012 on the restraint policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Physical Restraints will be utilized every week x 4, monthly x 3 and quarterly x 2 for at least 6 months. IDT to review CQI tools; an action plan will be implemented if threshold of 95% is not met**. See Exhibit E** ·Data will be collected by DNS/Designee from 1 st and 2 nd shifts submitted to the CQI committee. If threshold of 95% is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 11/18/12**	

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	released at meals, during personal care, while in bed, and when under direct supervision of staff or family. **3.1-35(g)(2)**			

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F0329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review, and interviews, the facility failed to ensure there were adequate indication for the use of antipsychotic medications, failed to ensure non-pharmaceutical interventions were attempted prior to the use of anti-anxiety and/or antipsychotic medications were initiated, and failed to ensure adequate behavior monitoring of the medical symptoms was documented for 7 of 10 residents reviewed for medication use.	F0329	**F 329 Drug Regimen is free from unnecessary drugs** It is the practice of this facility to ensure that each Resident's drug regimen is free from unnecessary drugs. Anti-psychotic drugs are not to be given unless to treat a specific condition/diagnosis along with supportive documentation that meets criteria from CMS to warrant the need for that medication. GDR's will then be implemented in an effort to discontinue the medication unless clinically contraindicated.	11/18/2012

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	(Residents #18, 41, 80, 151, 165, 175, and 247.) Findings include: 1. The clinical record for Resident #41 was reviewed on 10/18/12 at 9:30 A.M. Resident #41 was admitted to the facility on 07/27/12 from an acute care hospital. The resident's diagnoses included but were not limited to: Acute T2 T3 compound fracture, falls, dementia, osteoporosis, glaucoma, venous-statis, carpal tunnel syndrome, and compression fracture. Nursing progress notes, dated 07/30/12 at 8:46 P.M. indicated the resident was upset about being at the facility and wanted to go home. She moved her wheelchair backwards into the wall in frustration and the handle of the wheelchair put a hole in the wall. On 08/04/12 at 10:06 P.M., the resident became upset because her closet did not contain all of her clothes. In addition the resident continued to want to go home. On 08/05/12 at 6:37 P.M., the resident was agitated again and wanted to go home. She kept asking		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Interdisciplinary Team (IDT) will review residents #18, #41, #80, #151, #165, #175, #247 affected by the alleged deficient practice using the CQI psychotropic medication tracking form tool. To ensure non-pharmaceutical interventions are attempted prior to the use of the anti-anxiety/anti-psychotic medications and to ensure behavior monitoring of medical symptoms is documented. Social Services will discuss with the psychiatric clinician or neurologist on or before 11/18/12 regarding psychotropic medication management for those residents that were affected and make necessary changes as recommended by the psychiatric clinician or neurologist. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · Residents having	

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	people to give her a ride. An order for Ativan was obtained. On 08/06/12 at 10:00 P.M., the resident again expressed the desire to "go home." Staff explained why she was at the facility and gave her a pain pill and she was calmer. On 08/07/12 at 1:09 P.M. the resident was again upset about the "missing clothes" in her closet and wanted to go home. An order for a urinalysis was obtained. On 08/08/12 at 12:22 A.M., Resident #41 was agitated again about her missing clothes. The resident thought she was "at home" and her clothes had been taken from her closet. The nursing staff explained she only brought 5 shirts and two were in the closet, two were in the hamper, and one was in the laundry. The resident insisted she had a "whole closet full of clothes." Staff then "quizzed" her about the name of her home (assisted living facility resident had been residing in prior to fall). On 08/09/12 at 9:22 A.M., the resident again began repeatedly asking for her "things." She indicated she had clothes, her purse, and her other "stuff." Staff attempted to		psychotropic medications have the potential to be affected by the alleged practice. · Licensed staff and members of the interdisciplinary team including social services will be in-serviced on the behavior management program including gradual dose reductions. Education will be provided by Social Services Consultant/Designee and completed by November 18 th , 2012. · A house audit will be implemented by Social Services and will begin using a tool for tracking of psychotropic medications for those residents who are on psychotropic medications to ensure that all residents are free from unnecessary drugs. All new admissions and readmissions are reviewed in a.m. meeting with IDT to ensure the care plan, diagnosis, behavior tracking flow sheets are individualized and in place. **See Exhibit A.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · Licensed staff and members of the interdisciplinary team including social services will be in-serviced on the behavior management program including	

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	reorient the resident but she became very distraught, did not believe the staff, thought her items had been stolen. The resident was given Ativan to help her "rest." On 08/12/12 at 11:16 A.M., the resident started asking to go home. The resident asked staff and visitors for a ride home, asked to call her family. She then became agitated because she was not in her "home." She was redirected and informed social services and therapy would discuss the issue with her tomorrow and talk about her discharge plans. At 5:00 P.M., the resident became agitated and loud, tried to exit the facility repeatedly. The resident was medicated with Ativan for anxiety and given 1:1 attention which was effective. On 08/13/12 the resident's attending physician order Haloperidol, an antipsychotic medication and Trazadone, an antidepressant medication with sedating side effects. A physician's note, dated 09/07/12, indicated the Haloperidol was ordered due to "delusional disorder." On 8/31/12, a note to physician, indicated the resident continued to		gradual dose reductions. Education will be provided by Social Services Consultant/Designee and completed by November 18 th , 2012. · Prior to the licensed nurse administration of any prn medication or any new order of psychotropic medication the DNS/designee will be notified to ensure non-pharmaceutical interventions are implemented. · IDT to review all medication orders using the tool for tracking of psychotropic medications to ensure behavior management tracking and to ensure residents are free of unnecessary medications. **See Exhibit A** ·DNS is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ·A CQI monitoring tool called Unnecessary Medications will be utilized every week x 4, monthly x 3 and every other month x 3 for 6 months. **See Exhibit F** ·Data will be collected by DNS/Designee and submitted to the CQI Committee. If threshold of 95% is not met, an action plan will be developed.	

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	have problem behaviors through past week - screaming and hitting staff when they don't open the door for her or ask her to sit down in her wheelchair - asked to change Haldol and Trazadone to Risperidone. The request was not responded to by the physician. On 08/24/12 another note to physician indicated the resident has had many problem behaviors in the past week. She was "exit seeking, ramming w/c into staff, scratching, screaming at staff...her moods worsen at 6 PM...Ativan seems to help her to calm but takes awhile." Review of the behavior tracking for Resident #41 for August 15 - 31, 2012 indicated it tracked the following behaviors: #1 - anxiety aeb [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] fidgeting and worrisome thoughts such as people stealing her things and #2 - Insomnia aeb [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] not sleeping 6 - 8 hours daily. There were no behaviors noted on the tracking form for August 2012.		·Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Completion date: 11/18/12**	

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	An October 2012 behavior tracking form indicated the following behaviors were being tracked: #1 - anxiety aeb [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] [as evidenced by] fidgeting and worrisome thoughts such as people stealing her things #2 - Insomnia #3 - Verbal and physical agitation/aggression. There was no behavioral tracking or care plan to address the delusional behavior for which the resident was being administered, Haldol. In addition, prior to the order for the Haldol, there was no documentation of delusional disorder.. Review of the current heath care plans for Resident #41 indicated they included a plan, initiated on 08/20/12 for aggressive behaviors, a plan, initiated on 08/15/12 for insomnia, and a plan, initiated on 08/15/12 for anxiety. There were no care plan initiated prior to the obtaining and administration of both antianxiety, antipsychotic, and/or antidepressant medication. Interview with Nursing Consultant , employee #9 and Social Services			

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	Consultant, employee #10, on 10/19/12 at 11:00 A.M.., indicated the physician who had taken care of resident while she was in an assisted living facility had ordered the Haldol and indicated the reason was delusions. The Nurse Consultant indicated she was checking with the physician to see if there was anymore in site as to the reason Haldol was ordered. There was no further information obtained from the physician at the time of the survey exit for the facility. 2. The clinical record for Resident #18 was reviewed on 10/18/12 at 10:00 A.M. Resident #18 was admitted to the facility on 05/22/2008, with diagnoses including but not limited to, depression with withdrawal and decreased motivation, dylipidemia, reflux, personality disorder with borderline features, hx of hysterectomy, ddd, htn, moderate obesity, increased cholesterol, djd, dementia, bipolar disorder, delusions, gerd, seasonal allergies, dry eye, oad, hyperlipidemia, and diabetes mellitus. Review of the physician orders for Resident #18 indicated she was receiving, Lamictal, a mood altering medication, Faxaclo, an antipsychotic medication, Namenda, a medication			

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	to treat dementia, and Exelon patch, an antidepressant medication. Review of the current behavior tracking and health care plans, for October 2012, for Resident #18 indicated the following behaviors were being tracked: #1 - Hx of alteration in mental process with potential for injury to self, family members and/or staff and #2 - Manipulative behavior. Interview with Social service designee, employee #5, on 10/19/12 at 11:00 A.M. indicated she had not been working in the facility very long and was not able to discuss behavior tracking and antipsychotic medication use for Resident #18. Interview with the Social services consultant, employee #10, on 10/19/12 at 11:10 A.M., indicated the care plan regarding behavior tracking for Resident #18 was not clear as to what to what the actual behavior being tracked. 3. The clinical record for Resident #175 was reviewed on 10/18/12 at 2:30 P.M. The resident was admitted to the facility on 10/19/11 and readmitted to the facility on 07/02/12 with diagnosis, including but not			

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	limited to falls with fracture and scalp lacerations, senile dementia, insomnia, anemia, anxiety, and hx of urinary tract infection. Physician's orders, dated 04/20/12 indicated an order for Ativan .5 mg every 8 hours as needed for anxiety. On 05/03/12 an order was received for Ativan .5 mg every 8 hours routinely for anxiety. On 05/10/12 an order to utilize the as needed Ativan could be used for anxiety induced by insomnia, along with the routinely ordered Ativan as long as the resident did not receive more than 2 mg of Ativan in a 24 hour period. A care plan regarding anxiety was not initiated until 06/29/12. The resident was readmitted for an acute care facility on 07/04/12. Physician orders on 07/04/12 indicated the resident was receiving Ativan, an antianxiety medication, twice a day and as needed for anxiety and/or agitation, and Keelson patch for depression, and an antidepressant, Remeron at bedtime. On 07/09/12 an order for Ambien, a hypnotic was ordered at bedtime per a family request due to insomnia. On			

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	155756	A. BUILDING 00 B. WING	10/19/2012

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	07/11/12, the Ambien was discontinued and an order was received for Tylenol PM one tablet at bedtime, may repeat one time a night due to insomnia. On 07/27/12 another hypnotic, Lunesta 2 mg at bedtime was added for insomnia, a medication to treat restless leg syndrome, Lyrica was also added. Review of the care plans for Resident #175 indicated plan, current through 12/11/12 for Behavioral symptoms - signs and symptoms of anxiety, insomnia, and depression. The only plan to address restless leg syndrome indicated a plan to administer the medication. No non-pharmaceutical interventions were documented. Review of the nursing progress notes from 07/04/12 - 07/09/12 indicated there was no documentation of any insomnia behavior. Nursing notes, from 07/10/12 - 07/11/12 indicated there was no documentation again of any increased insomnia issues. Nursing notes, from 07/12/12 - 07/27/12 indicated on 07/18/12 the resident had some insomnia around 4:00 A.M., however the resident was being tested for a possible urinary			

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	tract infection. On 07/23/12 the resident's husband informed staff the resident was anxious and not sleeping well. The urinalysis test was still pending with the laboratory at the time. There were no interventions besides family at bedside and medications documented as having been attempted regarding the insomnia. Interview on 10/19/12 at 8:45 A.M., with the Director of Nursing Consultant, employee #10, indicated in June 2012 the Corporate Social Service staff did a "webinar" inservice with facility social service staff regarding antipsychotic reduction action plans in regards to CMS initiatives. Then the Corporate Social Services staff conducted "conference calls" with facility Social Services staff throughout the summer. Interview with Social Services Consultant, on 10/19/12 at 10:00 A.M., indicated the facility if working towards an individual tracking plan to make sure the behavior and care plans were in place for residents receiving antipsychotic medications.			

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	4. The clinical record for Resident #80 was reviewed on 10/17/12 at 1:30 P.M. Resident #80 was admitted to the facility on 08/04/2007 with diagnoses including but not limited to: CVA (cerebral vascular accident), Alzheimer's, Osteoporosis, htn (hypertension), allergic rhinitis, dementia with behavior disturbance, delusions, depression, hyperlipidemia, hypothyroidism, osteoarthritis, left hemiplegia, dementia, Brady cardiac, and pvd (peripheral vascular disease). Review of the physician's orders indicated an order, dated 07/31/12 for the antipsychotic medication, Zyprexia. Review of a "Behavior Events" note, dated 05/10/12 at 4:23 P.M. indicated the resident was exit seeking, yelling out "help" loudly, scratching, pulling hair, and attempting to bite staff when redirected. The resident was moved to a quiet area and given space. An order for the antianxiety medication, Ativan was obtained. In addition, a urinalysis test was obtained. The resident had currently been receiving antibiotic medication for an eye infection.			

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	Review of nursing progress notes and behavior tracking forms for May 2012 indicated there were no other behaviors documented to support the use of the Zyprexa for Resident #80. Behavior tracking records for June 2012 indicated on 06/11/12 on the evening shift the resident exhibited three episodes of either exit seeking or wandering in her wheelchair into other resident's rooms. The non-pharmaceutical interventions attempted were documented as effective. However, on 06/12/12, the physician increased the resident's Zyprexa to 5 mg at bedtime due to dementia with behavioral disturbances. The care plan, current through 11/2012, indicated a plan to address the resident's resistiveness to care. The plan indicated the resident would yell, hit, kick, bite, scratch, pinch to indicate that she does not want to get up or receive care. There was also a plan regarding the resident's delusional behavior however, delusions and resistive behaviors were not being tracked on the behavior tracking records.. Interview, on 10/19/12 at 11:00			

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	A.M., with both Social Service Directors, employees #4 and 5 indicated they had only been at the facility for a short time and did not feel they could discuss Resident #80's psychotropic medications and/or behaviors. 5. Resident # 151's clinical record was reviewed on 10/17/12. The record indicated the resident was admitted to the facility on 9/12/12 and had diagnoses including, but not limited to, dementia with delusions and depression. Review of resident # 151's physician's orders indicated the resident has been receiving Risperdal (an antipsychotic medication) 0.25 milligrams (mg) by mouth at bedtime for dementia with delusions since admission. Review of the resident's health care plans, current through 12/11/12, indicated no health care plan for dementia with delusions. No health care plans were located for the use of Risperdal. An interview with LPN #5 on 10/17/12 at 1:15 p.m. indicated the resident had no health care plan related to Risperdal use for dementia with			

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	delusions. An interview with the assistant director of nursing (ADN) on 10/17/12 at 1:20 p.m. indicated behavior tracking for residents was kept in the medication administration records (MAR). The ADN indicated review of resident #151's MAR did not contain any behavior tracking. An interview with resident #151's Social Service coordinator, employee #15, on 10/17/12, indicated the resident had no health care plan for dementia with delusions and no behavior tracking. 6. Resident #165's record was reviewed 10-19-2012 at 10:02 AM. Resident #165's diagnoses included but were not limited to dementia with psychosis, depression, and agitation. A review of the current physician's order sheet indicated Prozac (an antidepressant) 20 milligrams (mg) had been prescribed every day for depression and Risperdal 0.25 mg ii tabs daily for dementia with psychotic features.			

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	Behavior tracking for 10-2012 included, behaviors of yelling and threatening others. Behavior tracking for periods of anxious moods Resident #165 was not able to verbalize included no behaviors, but the interventions of meds as ordered indicated medications had been given despite the absence of behavior. A review of nurse's notes from May through October 2012 indicated no behaviors. A review of the Minimum Data Set information (MDS) for the periods of 2-28-2012, 5-23-2012, and 8-15-2012 indicated no moods, delusions/ hallucinations or behaviors in the assessment reference periods. A care plan dated 11-9-2011 titled anxious mood resident is unable to verbalize included interventions of medications as ordered, observe for changes in routine that may indicate changes in feelings of anxiousness. There were no other non pharmacological interventions. A care plan titled yelling at and threatening others included interventions of follow through with what you told resident you were going			

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	to do, establish an understanding of the expectations and outcomes you would like to see, orient resident to his surroundings,and talk with resident in calm voice and manner. A care plan titled diagnosis of depression included interventions of assist to and from day room and lunch, determine resident likes and interest, and introduce to residents with similar interests. A care plan titled dementia dated 9-19-2011 included interventions of encourage ongoing support from family, introduce to other residents with similar interests, introduce self at each interaction, and show resident the common area of the facility. In an interview on 10-19-2012 at 12:08 PM LPN #2 indicated she was unsure if the Risperdal or Prozac was being given for anxiety. LPN #2 further indicated staff should be attempting nonpharmacologic interventions despite routine medications for depression and dementia with delusions. 7. Resident #247's record was reviewed 10-17-2012 at 10:37 AM. Resident #247's diagnoses included but were not limited to dementia, high			

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	blood pressure, and enlarged heart. A review of a current physician's order summary dated 10-2012 indicated Xanax (an antianxiety medication) 0.5 milligrams (mg) had been ordered every 6 hours as necessary for anxiety. A review of the Medication Administration Record (MAR) indicated resident #247 had received Xanax 0.5 mg 10-13, 10-15, and 10-16-2012 for anxiety. A note on the back of the October MAR indicated all doses were effective. There was no indication non-pharmacological interventions had been attempted. In an interview on 1-17-2012 at 11:08 AM LPN #1 indicated interventions attempted prior to as necessary dosing were on the back of the MAR or in nurse's notes. A review of Nurse's notes dated 10-13, 10-15, and 10-16-2012 did not reveal any mention of the administration of Xanax or of the reason for giving the medication or any non-pharmacological attempt prior to it's administration. A care plan titled depression as evidenced by tearfulness, sad			

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	expression, and verbalization dated 10-12-2012 included interventions of encourage to voice emotions, refer to psychiatrist as needed, talk to resident about favorite things, and redirect to an activity. In an interview on 10-17-2012 at 1:12 PM SSD #4 indicated behavior tracking was on the MAR. In an interview on 10-17-2012 at 1:13 PM LPN #1 indicated behavior tracking was in the MAR. She further indicated Resident #247 had not been tracked as far as she knew for behaviors or anxiety. LPN #1 further indicated non pharmacological intervention should have been attempted before as necessary Xanax was used. In an interview on 10-17-2012 at 1:15 PM SSD #4 indicated no behavior had been tracked because the physician had just changed the medications and there was no tracking necessary. SSD #4 further indicated there should have been non pharmacological attempts prior to the use of necessary Xanax. 3.1-48(b)(1) 3.1-48(b)(3) 3.1-48(b)(4) 3.1-48(b)(5)			

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